Instructions on how to complete the Authorization for Release of Patient Information Form.

Please complete the sections that are highlighted. We must have complete information before we can release the record.

Following is the information for completing this document. This is to be completed by the Patient, Legal Guardian or the Power of Attorney only.

The Name, Date of Birth and Social Security number highlighted at the top of the page belong to the patient and must be completed to ensure we release the correct information.

In the section labeled "release information to" this will be the person(s) name, (or your physician's name) that you want to receive your information. Please include their complete mailing address including city, state and zip code and telephone number. NOTE: **All information is sent USPS Certified, Return Receipt Requested mail and must be signed for. If it is returned to us as unclaimed or undeliverable, any future request must be picked up in person in our office.**

In the next area check the appropriate box for how you wish the information to be released to you. Please note the above information if you are requesting that we mail you the documents.

Please make sure to mark the appropriate boxes for the information you are requesting.

In the area marked "Release of Records is for the purpose of" please give a brief description of the reason you are requesting the release and be sure to mark one of the two boxes below this section.

All authorizations expire in 6 months unless you complete the line above this statement.

Please Date and sign at the bottom, include your authority to obtain the records you are requesting.

Please include a copy of the patients identification and your identification (drivers license, gov't issued ID) that is clear and legible.